such agency to the state and will be recouped through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, and such agency's actual per-patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling will be remitted to each such agency by the Department in a lump sum amount.

(f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.

(g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than $200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to $200 million. Such reconciliation will not be subject to subsequent adjustment.

(h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.

(i) Effective May [1]2, 2012, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age and effective May 2, 2012, except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department, [shall] will be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences. Effective May 2, 2012, such case mix adjustments will include an adjustment factor for CHHAs providing care to Medicaid-eligible patients, more than 50%, but no fewer than two hundred, of whom are eligible for OPWDD services.

The initial statewide episodic base price to be effective May [1]2, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

February of 2010, will be included in the base price calculation. Low utilization episodes of care, as defined below, shall be excluded from the base price calculation. For high utilization episodes of care, costs in excess of outlier thresholds shall be excluded from the base price calculation. The remaining costs will be divided by the number of episodes to determine the unadjusted base price. The resulting base price shall be subject to further adjustment as is required to comply with the aggregate savings mandated by paragraph (b) of subdivision 13 of section 3614 of the Public Health Law (PHL). The applicable base year for determining the episodic base price will be updated not less frequently than every three years.

The case mix index applicable to each episodic claim, excluding low utilization claims, shall be based on patient information contained in the federal Outcome Assessment Information Set (OASIS). The patient shall be assigned to a resource group based on data which includes, but is not limited to, clinical and functional information, age group, and the reason for the assessment. A case mix index shall be calculated for each resource group based on the relative cost of paid claims during the base period.

To determine the case mix adjustment factor for agencies providing care to Medicaid-eligible patients of whom more than 50%, and no fewer than 200, are eligible for OPWDD services, total Medicaid claims reimbursement received by each qualified agency during the statutory base year for the Episodic Payment System (calendar year 2009) will be compared to the projected total reimbursement that would result from applying the episodic methodology to the same services billed in the base year. If the projected episodic reimbursement is less than the actual base year reimbursement, the percentage difference will be applied to the case mix index for all of the agency's episodic claims in order to equalize the traditional fee-for-service and estimated episodic reimbursement totals. All of the provider's episodic rates (which consist of case mix index multiplied by the statewide base price) will be increased by this percentage.

A regional wage index will be calculated for each of the ten labor market regions in New York as defined by the New York State Department of Labor. Average wages will be determined for the health care service occupations applicable to certified home health agencies. The average wages in each region shall be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories reported in the most recently available agency Medicaid cost report submissions. Weighted average wages for each region will be compared to the statewide average wages to determine an index for each region. The wage index will be applied to the portion of each payment which is attributable to labor costs. If necessary, the Department will adjust the regional index values proportionately to assure that the application of the index values is revenue-neutral on a statewide basis.

Payments for low utilization cases shall be based on the statewide weighted average of fee-for-service rates for services provided by certified home health agencies, as adjusted by the applicable regional wage index factor. Low utilization cases will be defined as 60-day episodes of care with a total cost of $500 or less, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, calculated prior to the application of the regional wage index factor.